CUSTOMER FOCUSED HEALTH CARE DELIVERY AND SATISFACTION
JUNE 2003

Accid Emerg Nurs. 2003 Jan;11(1):22-6.
Being a non-urgent patient in an emergency care unit--a strive to maintain personal integrity.
Nystrom M, Nyden K, Petersson M.
School of Health Sciences, Boras University College, Gothenburg, Sweden.
The aim of this study was to analyse and describe experiences of being a non-urgent patient in an ECU (emergency care unit). Eleven non-urgent patients were interviewed. The research approach was inductive and interpretative. Seven tentative interpretations and an interpreted whole, i.e., an existential interpretation, revealed that the informants tried to be 'good' patients by not demanding much attention from nursing personnel, in an attempt to maintain good relations with the nurses in order to be assured of a positive reception. As health related problems jeopardize personal integrity, patients cannot afford the risk of being looked upon as inappropriate clients in the ECU.
PMID: 12718947 [PubMed - indexed for MEDLINE]

AIDS Read. 1999 Oct;9(7):462-9.
The patient's perspective on life with antiretroviral treatment: results of an 887-person survey.
Bertholon DR, Rossert H, Korsia S.
AIDES Federation Nationale, Paris, France.
Soon after treatment with protease inhibitors became widespread, health care providers understood that adherence was essential to prevent emergence of drug-resistant viral strains. However, little was known about factors influencing adherence among patients with HIV infection. To help clarify the patient's perspective, AIDES, a French AIDS service consortium, conducted a survey of 887 patients between June 1 and July 15, 1997, in its 110 chapters throughout France and through its quarterly newsletter, Remaides. Fatigue and gastrointestinal side effects were the most frequent complaints, but patients reported that their greatest difficulty was that of confronting lifelong treatment with no possibility of discontinuation.
PMID: 12737138 [PubMed - indexed for MEDLINE]

Am J Public Health. 2003 May;93(5):822-7.
R.J. Reynolds' targeting of African Americans: 1988-2000.
Balbach ED, Gasior RJ, Barbeau EM.

Community Health Program, Tufts University, 112 Packard Avenue, Medford, MA 02155, USA. edith.balbach@tufts.edu
OBJECTIVES: The purpose of this study was to describe RJ Reynolds (RJR) Tobacco Company's strategy for targeting African Americans, as revealed in tobacco industry documents and magazine advertisements. METHODS: The authors searched industry documents to determine RJR's strategies and analyzed magazine advertising during 2 periods: the time of the launch of the company's Uptown cigarette (1989-1990) and a decade later (1999-2000). RESULTS: RJR's efforts to target the African American market segment existed before and after Uptown, and the company's strategy was largely implemented via other RJR brands. Advertisements featured mentholated cigarettes, fantasy/escape, expensive objects, and nightlife. CONCLUSIONS: To help all populations become tobacco-free, tobacco control practitioners must understand and counter tobacco industry strategies.
PMID: 12721151 [PubMed - indexed for MEDLINE]

Bioethics. 2003 Feb;17(1):1-20.
Care and the problem of pity.
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In recent years philosophers and bioethicists have given considerable attention to the concept of care. Thus we have seen important work on questions such as: whether there is a uniquely female approach to ethics, whether ethics should be partial or impartial, and whether care must be supplemented by justice. Despite this valuable and extensive work, however, some important distinctions have gone largely undiscussed. This paper tries to fill a gap left in our understanding of the concept of care itself by distinguishing between compassion and two kinds of pity. While all three are kinds of caring, we should not give them similar moral evaluations. Consequently, the distinction between compassion and different kinds of pity gives us an important insight into the question of whether we can consider care a virtue for health care professionals.
PMID: 12718330 [PubMed - indexed for MEDLINE]

Bioethics. 2003 Feb;17(1):21-31.
Futility without a dichotomy: towards an ideal physician-patient relationship.
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The futility debate may be considered as an effort to provide a clear and justified borderline between physician and patient decision-making authority. In this paper we argue that the search for a definition of futility that provides physicians with a final argument in discussions about life-prolonging treatment, is misplaced. An acceptable and meaningful criterion of futility that satisfies this effort seems impossible. As a consequence, we reject a dichotomous domain of decision-making power as the starting point for definitions of futility. A good decision about withholding life-sustaining treatment should be justified from the perspectives of both physician and patient. In this light, a range of definitions of futility is still useful as it can clarify intuitions that a treatment is inappropriate.
PMID: 12718331 [PubMed - indexed for MEDLINE]

BMJ. 2003 May 24;326(7399):1133-4.
Patient's view.
Hartl P, Sodeck G.
Department of Emergency Medicine, Vienna General Hospital, Wahringer Gurtel 8-20, A-1093 Vienna, Austria.
PMID: 12763988 [PubMed - indexed for MEDLINE]

Br J Community Nurs. 2003 Apr;8(4):181-7.
Older people as health service consumers 4: disempowered or disinterested?
Bentley J.
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Giving patients a greater say in the NHS is prominent in all national service frameworks (NSFs) and is evident in the expert patient initiative (Department of Health (DH), 2001a). One group of users who may have difficulty in making their voice heard are the elderly. The national service framework for older people (DH, 2001b) promotes user involvement in an attempt to achieve fair and equitable access to services for this group of patients who, statistically, make the highest use of the NHS and could be classified as consumers. This article, the last in a series on this topic, discusses whether a sample of older people in a village community have a consumerist ethos in regard to health care, and whether they are prepared to act in this way. Suggestions are made for better facilitating older people's involvement in and use of services.
PMID: 12732835 [PubMed - indexed for MEDLINE]

Br J Nurs. 2003 May 8-21;12(9):543-8.
Living theory: enhancing the psychological support of patients.
Hawkins J, Hollinworth H.
School of Health, Suffolk College, Ipswich.
This article explores how nurses, involved in a research project incorporating teaching psychological theories and counselling skills to enhance the psychological support of patients with wounds, had, one year on, changed their professional practice. This inquiry was framed by living theory, a concept previously only used in education, which is based on the integration of known knowledge, newly taught knowledge and increased self-awareness. The major principle of living theory is that one's values are questioned, modified, clarified and sometimes changed completely in striving to improve one's professional practice. This research showed nurses creating their own living theories, aspiring to really care for the whole person by developing strong, meaningful relationships with patients. The steps that participants took from first using the enhanced way of working with patients with wounds, to using it to support all patients psychologically, are demonstrated.
PMID: 12746591 [PubMed - indexed for MEDLINE]

Can J Cardiol. 2003 Mar 31;19(4):391-6.
Pharmacist's contribution in a heart function clinic: patient perception and medication appropriateness.
Bucci C, Jackevicius C, McFarlane K, Liu P.
The University Health Network, Toronto General Hospital, Toronto, Canada. claudia.bucci@swchsc.on.ca
BACKGROUND: It has been cited that the management of congestive heart failure (CHF) requires a multidisciplinary approach; however, the role of the pharmacist has not been extensively studied. The roles for pharmacists are changing to meet

the long term needs of patients in the community setting, including patients with CHF. OBJECTIVES: To evaluate the effect of a pharmacist on the appropriateness of medications taken by patients in the heart function clinic using the Medication Appropriateness Index (MAI) and to measure the effect of a pharmacist on the patients' response to the pharmacist's interventions using the Purdue Directive Guidance (DG) scale. METHODS: Eighty patients attending the heart function clinic at The University Health Network, Toronto General Hospital Toronto, Ontario were randomly assigned to an intervention group that received pharmacist services or a nonintervention group that received usual care from the clinic staff. Patients were assessed at baseline and at one-month follow-up. RESULTS: The change in MAI score from baseline was 0.74 and 0.49 for the intervention and nonintervention groups, respectively (P=0.605). The change in DG survey results was 9.97 and 1.00 for the intervention and nonintervention groups, respectively (P<0.001). The intervention group improved significantly in all components of the DG survey, especially those pertaining to feedback and goal setting. CONCLUSIONS: A benefit was demonstrated for 'directive guidance' of patients, in the form of education and goal setting as shown by positive survey results.
Publication Types:
Clinical Trial
Randomized Controlled Trial
PMID: 12704485 [PubMed - indexed for MEDLINE]

Clin J Oncol Nurs. 2003;7(2 Suppl):9-13.
The advocacy needs of patients with cancer and cancer survivors.
Gomez EG, McHale M.
PMID: 12703093 [PubMed - indexed for MEDLINE]

Clin J Oncol Nurs. 2003;7(2 Suppl):24-7.
Communication skills.
Lyter J.
Publication Types:
Review
Review, Tutorial
PMID: 12703095 [PubMed - indexed for MEDLINE]

Creat Nurs. 2003;9(1):14-5.
Hope embodied: 'compassionate, respectful care'.
Persigehl C.
PMID: 12715612 [PubMed - indexed for MEDLINE]

Crit Care Med. 2003 May;31(5):1597-8.
Comment on:
Crit Care Med. 2002 Jul;30(7):1413-8.
Family satisfaction with intensive care unit care: influenced by workload, staffing, and patient selection?
Polderman KH, Girbes AR, van Zanten AR.
Publication Types:
Comment
Letter
PMID: 12771649 [PubMed - indexed for MEDLINE]

Harv Bus Rev. 2003 May;81(5):86-92, 129.
Hedging customers.
Dhar R, Glazer R.
Yale School of Management, New Haven, Connecticut, USA.
You are a marketing director with $5 million to invest in customer acquisition and retention. Which customers do you acquire, and which do you retain? Up to a point, the choice is obvious: Keep the consistent big spenders and lose the erratic small ones. But what about the erratic big spenders and the consistent small ones? It's often unclear whether you should acquire or retain them and at what cost. Businesses have begun dealing with unpredictable customer behavior by following the practices of sophisticated investors who own portfolios comprising dozens of stocks with different, indeed divergent, histories and prospects. Each portfolio is diversified so as to produce the investor's desired returns at the particular level of uncertainty he or she can tolerate. Customers, too, are assets--risky assets. As with stocks, the cost of acquiring them is supposed to reflect the cash-flow values they are likely to generate. The authors explain how to construct a portfolio based on the notion that a customer's risk-adjusted lifetime value depends on its anticipated effect on the riskiness of the group it is joining. They also show how this approach was used to identify the best prospects for Myron Corporation, a global leader in the personalized business-gift industry. The concept of risk-adjusted lifetime value has a transforming power: For companies that rely on it, product managers will be replaced by customer managers, and the current method of accounting for profit and loss--which is by product--will be replaced by one that determines each customer's P&L. Once adjusted for risk, those P&Ls will become the firm's key performance and operational metric.
PMID: 12747165 [PubMed - indexed for MEDLINE]

Health Aff (Millwood). 2003 May-Jun;22(3):134-48.
Public reporting on quality in the United States and the United Kingdom.
Marshall MN, Shekelle PG, Davies HT, Smith PC.
National Primary Care Research and Development Centre, University of Manchester, England.
The public reporting of comparative information about health care quality is becoming an accepted way of improving accountability and quality. Quality report cards have been prominent in the United States for more than a decade and are a central feature of British health system reform. In this paper we examine the common challenges and differences in implementation of the policy in the two countries. We use this information to explore some key questions relating to the content, target audience, and use of published information. We end by making specific recommendations for maximizing the effectiveness of public reporting.
PMID: 12757278 [PubMed - indexed for MEDLINE]

Health Aff (Millwood). 2003 May-Jun;22(3):249; author reply 249.
Comment on:
Health Aff (Millwood). 2003 Mar-Apr;22(2):46-59.
Telling patients the truth.
Wu A, Pronovost P.
Publication Types:
Comment
Letter
PMID: 12757291 [PubMed - indexed for MEDLINE]

Health Aff (Millwood). 2002;Supp Web Exclusives:W160-1.
Comment on:
Health Aff (Millwood). 2002;Supp Web Exclusives:W139-54.
The role of the consumer in managed care's future.
Gellert JM.
Health Net, Inc., Woodland Hills, California, USA.
Publication Types:
Comment
PMID: 12703572 [PubMed - indexed for MEDLINE]

Health Care Women Int. 2003 Feb;24(2):93-102.
Promoting attentional health: importance to women's lives.
Stark MA, Cimprich B.
Bronson School of Nursing, Western Michigan University, Kalamazoo, Michigan 49008, USA. mary.stark@umich.edu
Promoting attentional health is an important opportunity to support and empower women to actively participate in their own health care and function effectively in multiple roles. Attention, the ability to focus or concentrate, is a necessary cognitive resource used throughout the life span in participating in self-health care. However, women can inadvertently overuse this essential capacity, especially when responding to life's multiple demands, resulting in mental or attentional fatigue. When women experience this mental fatigue, many daily activities, including self-health care, are more difficult. An attentional perspective in women's health allows approaches to improve daily functioning and reduce the risk of attentional fatigue. In this article we present the conceptual dimensions of directed attention and its relevance to women's health; practice and research implications are identified.
Publication Types:
Review
Review, Tutorial
PMID: 12746019 [PubMed - indexed for MEDLINE]

Health Care Women Int. 2003 Jan;24(1):40-8.
Women's views of a breast screening service.
Hamilton EL, Wallis MG, Barlow J, Cullen L, Wright C.
Breast Screening Service, Warwickshire, Solihull & Coventry, United Kingdom.
We performed this study to better understand women's views of the breast screening experience in order to improve the rate of uptake and the service offered. The sample comprised 27 women aged over 50 who had attended a regional breast screening service and received normal results. Data were collected through four focus groups. Results showed a need for a local, easily accessible breast screening unit with free car park facilities. Thus, women preferred a mobile screening unit that had a "cosy, nonclinical" atmosphere. Staff were reported to be efficient, caring, and helpful. Nonetheless, all women reported discomfort during the mammogram, and the nature of the procedure, during which women had their breasts squashed between two plates, was unexpected. Furthermore, women expressed anxiety about results, receiving recall letters, and about cancer in general. Women suggested the service should be advertised more widely and wanted more detailed information before and during screening. They demonstrated altruistic concern for other women who are currently excluded from the screening programme.
PMID: 12746030 [PubMed - indexed for MEDLINE]

Health Commun. 2003;15(2):219-26.
The communication of palliative care for the elderly cancer patient.
Ragan SL, Wittenberg E, Hall HT.
Department of Communication, The University of Oklahoma, Norman, OK 73019, USA. sragan@ou.edu
Palliative care (PC) is often recommended by physicians for their elderly patients who are terminally ill. In contrast to hospice care, which precludes the use of any curative treatment at life's end stages, PC seeks primarily to comfort patients and to keep them pain free, yet it does not necessarily preclude medical treatment. It does seek to attend to patients' physical as well as psychological, emotional, spiritual, and existential needs in an attempt to enhance overall quality of life. A review of current literature in PC for oncology patients, elderly and otherwise, reveals a curious irony: Although PC plausibly entails a holistic, patient-centered approach to health care, much of the research on PC and, apparently, many of the practices in PC focus almost exclusively on the biomedical approach to patient care, particularly in regard to pain and symptom management. Furthermore, few methods in PC research incorporate patients' narratives and lived experiences in the final stages of their lives. We argue that a holistic, patient-centered approach must guide research in PC, including the treatment of elderly patients as "active interpreters, managers, and creators of the meaning of their health and illness" (Vanderford, Jenks, & Sharf, 1997, p.14) and of the meaning of their lives.
PMID: 12742772 [PubMed - indexed for MEDLINE]

Health Commun. 2003;15(2):193-202.
Cancer survivorship and agency model: implications for patient choice, decision making, and influence.
O'Hair D, Villagran MM, Wittenberg E, Brown K, Ferguson M, Hall HT, Doty T.
Department of Communication, University of Oklahoma,, Norman, OK 73019, USA. hdohair@ou.edu
Relative to other types of health communication research (acute care physician patient communication, communication campaigns, compliance episodes, etc.), investigations of patient communication following the diagnosis of cancer are infrequent. Theoretically driven, empirical research is desperately needed in such postdiagnostic communication processes as survivorship, quality of life, palliative and hospice care, and loss, bereavement, and grief for those millions of people who have been diagnosed with the second leading cause of death in our nation. An organizational model of patient communication is needed that identifies and describes salient issues and processes involved when cancer patients attempt to negotiate the difficult courses of action following the diagnosis of cancer. The cancer survivorship and agency model (CSAM) proposes both general and specific strategies that serve as options for patients seeking to take greater control of the decision-making process related to their treatment and care of cancer. Although seemingly practical in its offering, CSAM is intended to serve as a heuristic springboard for theoretically based, applied communication research focusing exclusively on post diagnostic cancer processes.
PMID: 12742770 [PubMed - indexed for MEDLINE]

Health Commun. 2003;15(2):145-59.
Social identity and health: an intergroup communication approach to cancer.

Harwood J, Sparks L.
Department of Communication, University of Arizona, Tucson, AZ 85721, USA. jharwood@u.arizona.edu
This article describes the ways in which group identifications and stereotypes can inform our understanding of cancer prevention and treatment as well as more general social processes surrounding the experience of cancer. From a perspective grounded in social identity theory, we describe the ways in which understanding primary identities (i.e., those associated with large social collectives such as cultural groups), secondary identities (i.e., those associated with health behaviors), and tertiary identities (i.e., those associated with cancer) can help explain certain cancer-related social processes. We forward a series of propositions to stimulate further research on this topic.
PMID: 12742766 [PubMed - indexed for MEDLINE]

Hosp Peer Rev. 2003 May;28(5):69-72.
Responding to customer concerns improves quality. Part 2.
Spath P.
Brown-Spath & Associates Forest Grove, OR, USA.
PMID: 12747242 [PubMed - indexed for MEDLINE]

Insight. 2003 Jan-Mar;28(1):3-4.
Teaching patients advocacy.
Smith SC.
PMID: 12703248 [PubMed - indexed for MEDLINE]

Int J Palliat Nurs. 2003 Apr;9(4):166-72.
Breaking bad news revisited: the push for negotiated disclosure and changing practice implications.
Arber A, Gallagher A.
European Institute of Health and Medical Sciences, University of Surrey, UK.
This article revisits the ethical, legal, professional and emotional issues involved with disclosing bad news. The authors examine the push for disclosure that has come from a number of quarters in the UK, including ethical and legal challenges, in particular the Bristol Royal Inquiry Report, professional codes of conduct, health policy and the expectations of the public. The contribution of nurses to breaking bad news is not widely discussed in the literature. With the development of new nursing roles and evidence-based practice it is timely to consider the role of nurses in this process. The article highlights some limitations with current guidelines for breaking bad news, in particular, that these guidelines tend to be constructed from a professional standpoint and lack patient-centred evidence. The issue of emotional labour and how it relates to giving bad news is discussed with respect to professional staff and patients. The article concludes by raising some practice implications, including: the importance of context and continuity; the significance of information and support; the desirable qualities of the professional; and issues to consider in determining patient preferences.
PMID: 12734453 [PubMed - indexed for MEDLINE]

J Am Med Womens Assoc. 2003 Spring;58(2):69-75.

Effects of physician gender on patient satisfaction.
Bertakis KD, Franks P, Azari R.
Department of Family and Community Medicine, Center for Health Services Research in Primary Care, University of California, Davis, USA.
OBJECTIVES: To measure the impact of physician gender on patient satisfaction, controlling for confounding patient variables, and to examine the extent to which differences in satisfaction with male and female physicians can be explained by physician practice styles. METHOD: New adult patients (n=509) were randomized to see male and female primary care physicians at a university medical center outpatient facility. Patient sociodemographics and self-reported health status (using the Medical Outcomes Study Short Form-36) were measured before the initial visit, and satisfaction with the physician was measured immediately following the visit. The entire medical encounter was videotaped and physician practice style was later analyzed using the Davis Observation Code. RESULTS: Female physicians spent a significantly greater proportion of the visit on preventive services and counseling than male physicians did, and male physicians devoted more time to technical practice behaviors and discussions of substance abuse. Visit length was not significantly different for male and female physicians. Patients of female physicians were more satisfied than were those of male physicians, even after adjusting for patient characteristics, visit length, and physician practice style behaviors. CONCLUSION: Patient satisfaction with primary care physicians appears to be influenced not only by patient characteristics and physician behaviors, but also by the gender of the provider. Possible explanations for this may be that psychosocial aspects of the physician-patient interaction are different for male and female physicians. Patients may also bring expectations about female physicians to the encounter, presuming them to be more empathetic, nurturing, and responsive.
PMID: 12744418 [PubMed - indexed for MEDLINE]

J Am Med Womens Assoc. 2003 Spring;58(2):76-81.
What happens when health care providers ask about intimate partner violence? A description of consequences from the perspectives of female survivors.
Chang JC, Decker M, Moracco KE, Martin SL, Petersen R, Frasier PY.
University of North Carolina at Chapel Hill, USA. jchang@mail.magee.edu
OBJECTIVE: To describe positive and negative consequences of health care screening for intimate partner violence from the perspectives of female survivors. METHOD: We conducted 7 semistructured focus group interviews with 41 women in battered women's shelters or intimate partner violence support groups. RESULTS: Positive consequences of screening included: recognizing that the violence was a problem, decreased isolation, and feeling that the medical provider cared. Negative consequences included: feeling judged by the provider, increased anxiety about the unknown, feeling that the intervention protocol was cumbersome or intrusive, and disappointment in the provider's response. CONCLUSION: We found that both positive and negative consequences can result from screening for intimate partner violence and that they are related to provider behavior. The positive consequences described by the participants reflect changes in their attitudes, thoughts, and feelings that may precede help seeking. A better understanding of consequences can help providers tailor screening approaches and interventions for intimate partner violence.
PMID: 12744419 [PubMed - indexed for MEDLINE]

J Am Med Womens Assoc. 2003 Spring;58(2):117-9.
Patient choice of provider gender.

Adams KE.
Department of Obstetrics and Gynecology, Center for Ethics in Health Care, Oregon Health and Sciences University, Portland, USA.
As the proportion of women physicians in the United States increases, patients have increased access to physicians of either sex, and some patients express a clear preference for female providers. This is especially true in obstetrics/gynecology, where patients may have a variety of reasons for requesting female physicians. This column presents a case in which the patient not only expressed a preference for a female physician, but also, in fact, refused care from any male obstetrician/gynecologist. Possible responses to such a request are examined, with consideration of the competing priorities involved.
PMID: 12744426 [PubMed - indexed for MEDLINE]

J Contin Educ Health Prof. 2003 Winter;23(1):13-20.
Physicians' and patients' attitudes toward manual medicine: implications for continuing medical education.
Stoll ST, Russo DP, Atchison JW.
Department of Osteopathic Manipulative Medicine, Texas College of Osteopathic Medicine, University of North Texas Health Science Center, 3500 Camp Bowie Boulevard, Fort Worth, TX 76107, USA.
INTRODUCTION: Manual medicine (MM) is a physical modality infrequently used in primary care clinics. This study examines primary care physicians' experience with and attitudes toward the use of MM in the primary care setting, as well as patients' experience with and attitudes toward MM. METHODS: Surveys were distributed to a convenience sample of physicians (54.3% response rate) attending a 1-week primary care continuing medical education (CME) conference in Kentucky. Similar surveys were also mailed to a random sample of primary care patients (35.3% response rate) living in a service region in which most conference attendees practiced. RESULTS: Similar responses were obtained from physicians and patients. A majority (81% and 76%, respectively) of physicians and patients felt that MM was safe, and over half (56% of physicians and 59% of patients) felt that MM should be available in the primary care setting. Although less than half (40%) of the physicians reported any educational exposure to MM and less than one-quarter (20%) have administered MM in their practice, most (71%) respondents endorsed desiring more instruction in MM. The majority of those seeking additional educational exposure (56%) were willing to pay for MM training that included CME credit. DISCUSSION: This survey suggests that primary care physicians feel that there is currently insufficient education in MM. The majority of physicians and patients feel that MM is beneficial, safe, and appropriate for use in a primary care setting. Thus, there may be a rising demand for quality instruction in MM from physical medicine doctors and other licensed therapists who currently practice MM.
PMID: 12739255 [PubMed - indexed for MEDLINE]

J Fam Pract. 2003 May;52(5):392-3; author reply 393.
Comment on:
J Fam Pract. 2002 Oct;51(10):835-40.
Statistics to assess patient satisfaction with primary care called into question.
Ryan CW.
Publication Types:
Comment
Letter
PMID: 12765179 [PubMed - indexed for MEDLINE]

J Nurses Staff Dev. 2001 Jul-Aug;17(4):174.
A patient-centered approach to nurse orientation.
Dorando-Strong F.
Publication Types:
Letter
PMID: 12759998 [PubMed - indexed for MEDLINE]

J Palliat Care. 2003 Spring;19(1):54-7.
Using patients with cancer to educate residents about giving bad news.
Farber NJ, Friedland A, Aboff BM, Ehrenthal DB, Bianchetta T.
Christiana Care Health System, Wilmington, Delaware, USA.
PMID: 12710116 [PubMed - indexed for MEDLINE]

J Policy Anal Manage. 2003 Winter;22(1):65-84.
Hospital selective contracting without consumer choice: what can we learn from Medi-Cal?
Bamezai A, Melnick GA, Mann JM, Zwanziger J.
RAND, Santa Monica, California, USA.
In the selective contracting era, consumer choice has generally been absent in most state Medicaid programs, including California's (called Medi-Cal). In a setting where beneficiary exit is not a threat, a large payer may have both the incentives and the ability to exercise undue market power, potentially exposing an already vulnerable population to further harm. The analyses presented here of Medi-Cal contracting data, however, do not yield compelling evidence in favor of the undue market power hypothesis. Instead, hospital competition appears to explain with greater consistency why certain hospitals choose to contract with Medi-Cal while others do not, the trends in inpatient prices paid by Medi-Cal over time, and the effect of price competition on service cutbacks, such as emergency room closures. Copyright 2003 by the Association for Public Policy Analysis and Management.
PMID: 12722762 [PubMed - indexed for MEDLINE]

J R Soc Med. 2003 May;96(5):223-7.
Medically unexplained symptoms: exacerbating factors in the doctor-patient encounter.
Page LA, Wessely S.
Department of Psychological Medicine, Institute of Psychiatry, De Crespigny Park, London SE5 8AF, UK. l.page@iop.kcl.ac.uk
Publication Types:
Review
Review, Tutorial
PMID: 12724431 [PubMed - indexed for MEDLINE]

J R Soc Med. 2003 May;96(5):219-22.
Patients' memory for medical information.
Kessels RP.
Helmholtz Instituut, Utrecht University, Heidelberglaan 2, NL-3584 CS Utrecht, The Netherlands. r.kessels@fss.uu.nl
Publication Types:
Review
Review, Tutorial

PMID: 12724430 [PubMed - indexed for MEDLINE]

J Urol. 2003 Jun;169(6):2045-8.
Comparison of quality of life following laparoscopic and open prostatectomy for prostate cancer.
Hara I, Kawabata G, Miyake H, Nakamura I, Hara S, Okada H, Kamidono S.
Division of Urology, Kobe University Graduate School of Medicine, Kobe, Japan.
PURPOSE: We compare the quality of life after laparoscopic prostatectomy to that after standard radical prostatectomy. MATERIAL AND METHODS: The quality of life of 52 and 54 patients who underwent laparoscopic and open radical prostatectomy, respectively, was analyzed using the European Organization for the Research and Treatment of Cancer Prostate Cancer quality of life questionnaire for general health related quality of life, International Index of Erectile Function 5 for screening erectile dysfunction and International Continence Society MaleSF questionnaire to evaluate urinary status. These questionnaires were given to patients before and 6 months after surgery. RESULTS: The general health related quality of life survey revealed no significant differences in health before and after laparoscopic and open prostatectomy. However, sexual quality of life was markedly lower after surgery (p <0.01). In addition, the International Index of Erectile Function score was markedly abrogated by surgery (p <0.05) and quality of life due to urinary incontinence was significantly disturbed by surgery (p <0.05). In contrast, quality of life due to voiding dysfunction was impaired before surgery and significantly improved by surgery (p <0.05). Patients were also asked if they would choose the same treatment if suffering from the same disease, with more patients treated laparoscopically choosing the same treatment than those treated with open surgery (p <0.05). CONCLUSIONS: While general health related quality of life was not impaired, sexual quality of life was diminished by surgery. Patients were generally satisfied with postoperative urinary status. Although patients who underwent laparoscopic prostatectomy expressed a more favorable attitude toward surgery, there was no significant difference in quality of life at 6 months after surgery between the 2 groups.
PMID: 12771715 [PubMed - indexed for MEDLINE]

J Urol. 2003 Jun;169(6):2018-21.
Quality of life, pain and return to normal activities following laparoscopic donor nephrectomy versus open mini-incision donor nephrectomy.
Perry KT, Freedland SJ, Hu JC, Phelan MW, Kristo B, Gritsch AH, Rajfer J, Schulam PG.
Department of Urology, University of California-Los Angeles, Los Angeles, California, USA.
PURPOSE: We evaluated pain, convalescence and health related quality of life in patients undergoing laparoscopic and open mini-incision donor nephrectomy. MATERIALS AND METHODS: We compared the records of consecutive patients who underwent laparoscopic and mini-incision open donor nephrectomy from our donor nephrectomy data base in retrospective fashion using 2 questionnaires. The first questionnaire evaluated postoperative pain, return to functioning time and satisfaction. The second questionnaire was the RAND 36-Item Health Survey, version 2, a standardized and validated health survey quality of life assessment tool. Mean patient sex, age and followup were similar for the 2 groups. All data were analyzed using the 2-tailed t test for independent variables with commercially available statistical analysis software. RESULTS: Pain in the laparoscopic group was significantly less than in the mini-incision group at all

followup time points (p <0.05). Statistically significant differences demonstrated that laparoscopy led to more rapid recovery time in certain categories, including walking, discontinuation of prescribed oral pain relievers, return to driving, and resumption of normal work and home daily activities. More subjective questions in the survey showed high levels of acceptance for the 2 procedures. Using the RAND 36-Item Health Survey, version 2 health related quality of life was significantly higher in the laparoscopy group in 3 domains that measure bodily pain, physical functioning and emotional role functioning. However, each group scored at or above age matched American averages in all domains. CONCLUSIONS: The laparoscopy group had significantly less postoperative pain and required less time to return to normal functional activities than the mini-incision group. In addition, the laparoscopic group showed significantly higher quality of life scores than the mini-incision group in 3 domains.
PMID: 12771708 [PubMed - indexed for MEDLINE]

JAMA. 2003 Apr 23-30;289(16):2113-9.
Practical considerations in dialysis withdrawal: "to have that option is a Blessing".
Cohen LM, Germain MJ, Poppel DM.
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Cessation of life-support treatment is an appropriate option for situations in which the burdens of therapy substantially outweigh the benefits. Decisions to withdraw dialysis now precede 1 in 4 deaths of patients who have end-stage renal disease. Guidelines have been recently published to assist clinicians in making these complex and emotionally charged determinations, and they include: relying on shared decision making by all participants, obtaining informed consent, estimating the prognosis on dialysis, adopting a systematic approach for conflict resolution of disagreements, honoring advance directives, and ensuring the provision of palliative care. These principles are discussed in relation to an elderly man with dementia whose family decided to terminate maintenance hemodialysis.
PMID: 12709469 [PubMed - indexed for MEDLINE]

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What is best for the patient?
Harper A.
Publication Types:
Comment
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PMID: 12781579 [PubMed - indexed for MEDLINE]

Med Educ. 2003 May;37(5):480-1.
Communicating during procedures: development of a rating scale.
Nestel D, Kidd J, Kneebone R.
Centre for Medical & Health Sciences Education, Monash University, Clayton, Australia. debra.nestel@med.monash.edu.au

PMID: 12709204 [PubMed - indexed for MEDLINE]

Mil Med. 2003 Apr;168(4):274-9.
Gaps in expectations among clients of secondary medical services in the military system compared with the civilian system as a satisfaction index.
Goldberg A, Pliskin JS, Peterburg Y.
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The Israel Defense Forces Medical Corps operates a health network for Israel Defense Forces soldiers. Secondary medicine is included in the services to which soldiers are entitled. It is provided to military personnel through two parallel systems: within the Medical Corps specialists' clinics and through the auspices of a number of civilian hospital outpatient clinics. The military medical system, like the civilian medical system, is designed to serve its clientele. One of the indices for ascertainment of satisfaction with medical services is compatibility of client expectations with the service actually received. In this study, we present a gap index that demonstrates that there is gap in satisfaction among soldiers receiving secondary medical services from the military network compared with soldiers who receive secondary medical services from the civilian network. We designed a questionnaire administered to 1,532 soldiers and used 1,359 (89% response rate) for our analysis. The military system provides soldiers with services fully in synch with military regulations. Consequently, in most cases, there is a gap between soldiers' expectations from military medical service and the service they receive in practice-a phenomena that impairs soldier satisfaction. On the other hand, soldiers receiving medical services and treatment from the public civilian system receive, for the most part, service and treatment that meets or even exceeds their expectations because the system operates according to other regulations.
PMID: 12733670 [PubMed - indexed for MEDLINE]

Nurs Stand. 2003 May 7-13;17(34):33-6.
Using self-efficacy as a client-centred outcome measure.
Fleming G, McKenna M, Murchison V, Wood Y, Nixon J, Rogers T, Hutcheson F.
Soutra Day Unit, Herdmanflat Hospital, Haddington, East Lothian.
BACKGROUND: The concept of self-efficacy has been proposed as a suitable outcome measure in psychiatry. Self-efficacy refers to an individual's belief that he or she can control important aspects of his or her life. An audit of 67 consecutive clients attending an acute psychiatric day unit was conducted, measuring self-efficacy at admission to the unit and at discharge. CONCLUSION: The concept of self-efficacy was easily explained to clients, and was measured using a 15-point questionnaire. Self-efficacy increased following treatment in the day unit, and this increase appears to reflect an underlying change in the individual's self-belief.
Publication Types:
Validation Studies
PMID: 12764973 [PubMed - indexed for MEDLINE]

Nurs Times. 2003 Apr 15-21;99(15):18-9.
Are nurses losing sight of the patient?
Gough P, Cosgrove J.

King's Fund, London.
Publication Types:
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PMID: 12733285 [PubMed - indexed for MEDLINE]

Nurs Times. 2003 Apr 8-14;99(14):38-9.
Power to the patients.
Crouch D.
PMID: 12718285 [PubMed - indexed for MEDLINE]

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Taking steps to control patients' pain.
[No authors listed]
PMID: 12723325 [PubMed - indexed for MEDLINE]

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Online doctor-patient communication tool saves time on phone.
[No authors listed]
Online tool enables patients to consult with physicians maore efficiently. The Medical Clinic of North Texas recently implemented an online communication tool that enables physicians and patients to communicate electronically, resulting in greater efficiency and improved patient care.
PMID: 12741041 [PubMed - indexed for MEDLINE]

Res Theory Nurs Pract. 2003 Spring;17(1):65-84.
Meaning of dependency on care as narrated by 10 patients.
Strandberg G, Norberg A, Jansson L.
Department of Nursing, Umea University, Sweden.
This article is part of an ongoing study that aims to illuminate the meaning of dependency on care. The aim of this particular study is to disclose the meaning of dependency on care as narrated by patients. We conducted interviews with patients (six men and four women) who had been in medical or surgical wards for at least 14 days. Seven of the patients were also interviewed one week after discharge. The participants ranged in age from 41 to 84 years old. The interviews were tape-recorded and transcribed verbatim. A phenomenological-hermeneutic approach was used to interpret the resulting text. The results show that to be dependent on care is to face the inevitability of not being able to manage by oneself--it is being attached to the nurses and bound to the care they offer. Being dependent on care involves a struggle to get care without treading on the nurses' toes. The nurses are one's lifelines and getting care is essential, no matter what. It is better to receive any form of care, good or bad, than to receive nothing. Being dependent on care is to be exposed and subjected to a nurse's ability and benevolence. One comprehensive understanding of the meaning of dependency on care is simply that "one does not saw off the branch one is sitting on." Furthermore, dependency on care involves a struggle to move forward in a life that hurts. Patients lose much of their freedom of choice in daily life and grieve their loss of ability and value. Patients may be able, however, to see things they would have never noticed earlier in life. Dependency on care is understood as one kind of "limit

situation." Patients who are dependent on care may reevaluate their potential in life and gain another perspective on life.
PMID: 12751886 [PubMed - indexed for MEDLINE]

Scand J Prim Health Care. 2003 Mar;21(1):27-32.
Exploration of the relationship between continuity, trust in regular doctors and patient satisfaction with consultations with family doctors.
Baker R, Mainous AG 3rd, Gray DP, Love MM.
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& Primary Health Care, University of Leicester, Leicester General Hospital, UK. rb14@le.ac.uk
OBJECTIVE: To determine the influence of longitudinal continuity and trust in patients' regular family doctors on patient satisfaction with consultations. DESIGN: Observational questionnaire study. SETTING: Three family practice centres in the USA and four general practices in the UK. SUBJECTS: 418 patients in the USA and 650 in the UK who were consulting family doctors. MAIN OUTCOME MEASURES: A pre-consultation questionnaire sought information about the patient's experience of continuity and trust in their regular doctor; a post-consultation questionnaire measured satisfaction with the consultation. RESULTS: 78.8% of patients rated seeing the same doctor every time they had a health problem as important or very important. Trust in the regular doctor, consulting the regular doctor and country were the strongest predictors of satisfaction. Patients who had a high level of trust in their regular doctor and consulted that doctor had the highest levels of satisfaction with their consultations. Among patients with relatively low levels of trust in regular doctor, levels of satisfaction were similar whether or not they consulted their regular doctor. CONCLUSIONS: Consulting the regular doctor, trust and satisfaction with consultations are associated, and patients who consult a doctor they trust report the highest levels of satisfaction with consultations.
PMID: 12718457 [PubMed - indexed for MEDLINE]

Womens Health Issues. 2003 Mar-Apr;13(2):55-61.
The organization and delivery of women's health care in Department of Veterans Affairs Medical Center.
Yano EM, Washington DL, Goldzweig C, Caffrey C, Turner C.
VA Greater Los Angeles Health Services Research and Development (HSR&D) Center of Excellence, VA Sepulveda Ambulatory Care Center and Nursing Home, Sepulveda, California 91343, USA. elizabeth.yano@med.va.gov
Congressional eligibility reforms have profoundly changed the array of services to be made available to women veterans in Department of Veterans Affairs (VA) health care facilities. These include access not only to primary and specialty care services already afforded VA users, but also to a full spectrum of gender-specific services, including prenatal, obstetric, and infertility services never before provided in VA settings. The implications of this legislative mandate for delivering care to women veterans are poorly understood, as little or no information has been available about how care for women veterans is organized. This article reports on the first national assessment of variations in the organization of care for women veterans.
PMID: 12732441 [PubMed - indexed for MEDLINE]

Womens Health Issues. 2003 Mar-Apr;13(2):50-4.
Availability of comprehensive women's health care through Department of Veterans Affairs Medical Center.
Washington DL, Caffrey C, Goldzweig C, Simon B, Yano EM.
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Despite increased numbers of women veterans, little is known about health services delivery to women across the Department of Veterans Affairs (VA). To assess VA availability of women's health services, we surveyed the senior clinician at each VA site serving 400 or more women veterans. We found that virtually all sites have developed arrangements, either directly or through off-site contracts, to ensure availability of comprehensive women's health care. On-site care, however, is routinely available only for basic services. Future work should evaluate cost and quality trade-offs between using non-VA sites to increase specialized service availability and using VA sites to enhance continuity of care.
PMID: 12732440 [PubMed - indexed for MEDLINE]